

# Who Benefits from Increasing Health Insurance Subsidies: Patients or Providers?

By Marika Cabral

## KEY TAKEAWAYS

- Medicare Advantage (MA) plans cover nearly 20 million people — about 34 percent of the Medicare beneficiary population.
- Roughly half of MA subsidy increases are passed on to beneficiaries in the form of lower premiums or improved benefits.
- Pass-through of subsidy payments to MA beneficiaries varies greatly, ranging from 13 percent in the least competitive markets to 74 percent in the most competitive.
- As many MA markets are highly concentrated, limited pass-through of subsidies is a pressing concern for seniors who depend on Medicare for health care coverage.

Medicare is one of the pillars of the U.S. social insurance system and the primary source of health care coverage for those over 65. More than 58 million people were enrolled in Medicare in 2017. In that year, Medicare spending grew to \$705.9 billion, up 4.2 percent from the year before, representing 20 percent of total national health expenditures (U.S. Centers for Medicare & Medicaid Services 2019).

Since originating in 1965 as a federal government insurance program, Medicare has increasingly become privatized. So have other publicly funded health insurance programs, such as Medicaid, which provides health care coverage to low-income individuals. Medicare's private plan option, known as Medicare Advantage (MA), is based on a system of subsidies to private insurance providers designed to compensate them for bearing the risks and costs of managing health care for seniors. In addition to collecting these government payments, insurers often charge enrollees a premium.

In most of the United States, Medicare beneficiaries can choose between the traditional fee-for-service program, in which the federal government pays health care providers directly, or a private MA plan. Enrollment in MA plans has roughly doubled over the past decade. By 2018, MA covered nearly 20 million people, or about 34 percent of the Medicare beneficiary population.

## Do Medicare Advantage Subsidies Go to Plan Members or Providers?

MA subsidies to private insurers have been adjusted up or down a number of times in the history of the program. Most recently, the Affordable Care Act included an estimated \$156 billion reduction in MA subsidies (Kaiser Family

Foundation 2010). These adjustments have spurred a sharp debate. If subsidies are raised, how much of these higher payments are passed through to Medicare enrollees in the form of lower premiums and more generous benefits and how much goes to health care providers, including insurers, doctors, and hospitals? Similarly, when subsidies are trimmed, how much do providers take a hit and how much are premiums raised or benefits cut to keep profits intact? Simply put, do changes to MA subsidy levels impact patients or providers more?

In a recent paper, my University of Texas colleague Michael Geruso, Neale Mahoney of the University of Chicago Booth School of Business, and I took advantage of a legislative overhaul that raised MA subsidies to examine how gains were distributed (Cabral, Geruso, and Mahoney 2018).

Congress enacted the Benefits Improvement and Protection Act (BIPA) in 2000. The law instituted far-reaching changes in how capitation, or per-beneficiary, payments to MA providers were calculated. These payments previously had been based largely on historical expenditures of the traditional Medicare program at the county level. BIPA created a system of rural and urban payment floors that boosted subsidies in 72 percent of U.S. counties. Previously, capitation payments in those counties had been on a similar track as payments in counties unaffected by the new floors. But when the new subsidy calculation method was implemented, per-beneficiary payments rose \$600 per year on average, or 12 percent, in the counties where the floors were binding.

These sharp payment increases represent a natural experiment allowing us to analyze how higher subsidies were apportioned and the extent to which these increases reduced MA premiums and improved coverage. To estimate how much of the MA subsidy increases went to beneficiaries, we used an empirical strategy known as difference-in-differences to compare changes in counties affected by the new floors with changes in unaffected counties.

We found that MA plans passed along a little over half their capitation payment increases to beneficiaries in the form of lower premiums or improved benefits.

For each dollar in higher payments, we estimate MA premiums fell about 45 cents in the three years following the change. In addition, an estimated 9 cents went to MA enrollees in the form of more-generous benefits, such as lower medical co-payments and added coverage.

That combination of lower premiums and improved benefits indicates a total pass-through rate of 54 percent. Statistically, we have 95 percent confidence that the combined subsidy pass-through rate fell between 37 percent and 71 percent. Moreover, we found that affected counties and unaffected counties were following the same trend before the new payment system was implemented. This suggests that the patterns observed when BIPA was implemented were a result of the subsidy increases.

We investigated the possibility that MA plans were improving coverage in ways that couldn't easily be measured, such as offering better customer service. However, a review of beneficiary evaluations and survey data yielded no evidence of changes in plan quality other than the premiums and benefits we studied.

## Explaining Incomplete Pass-Through of Medicare Advantage Subsidies

Under certain economic assumptions, such as a fully competitive insurance market, the entire MA subsidy increase should be passed through to beneficiaries. In our theoretical model, two explanations for partial pass-through are possible:

- When MA insurers lowered premiums, they may have attracted a riskier, less-healthy pool of beneficiaries. This advantageous selection of beneficiaries could lead to higher health care costs, which would prompt insurers to adjust premiums upward to recover these additional expenses. Thus, even in a highly competitive market, insurers would not be able to fully pass through MA subsidies.

- A county MA market may not be fully competitive. A high degree of concentration, that is, with one or more firms holding dominant market share, would give providers market power to set quasi-monopolistic prices and keep a large share of the subsidy increases.

To investigate the possible impact of advantageous selection, we analyzed how the BIPA-generated payment shock impacted enrollment in MA and insurer costs. For this analysis, we use data on traditional Medicare beneficiaries to estimate how the selection of beneficiaries into MA (and out of traditional Medicare) impacted MA insurer costs. We found limited advantageous selection into MA plans. In our model, under conditions of perfect competition, increased risk in the beneficiary pool would reduce pass-through to an estimated 85 percent. In other words, of the 46 cents of every dollar of increased subsidy not passed through to beneficiaries, advantageous selection accounts for 15 cents, or about a third of the gap between the share passed through to consumers and full pass-through.

That leaves market power as a possible explanation of incomplete pass-through. We used two measures of pre-BIPA competition to determine the degree of insurer market power in a county: (1) the Herfindahl-Hirschman Index (HHI), a standard statistical metric of competition in a market; (2) the number of firms offering MA plans. Both metrics showed a strong relationship between market concentration and incomplete pass-through.

On the first point, we divided counties into three groups ranging from most to least concentrated according to the insurer HHI. In the most concentrated counties, where market power was greatest, pass-through was a mere 13 percent. By contrast, in the least concentrated counties, we estimated pass-through at 63 percent. Similarly, in counties with just one insurer, our pass-through estimate was also 13 percent. But in counties with three or more insurers, pass-through rose to 74 percent. In sum, pass-through of subsidy payments to MA beneficiaries varies greatly, ranging from 13 percent in the least competitive markets to 74 percent in the most competitive.

Our results do not address how the share of subsidies not passed through to MA beneficiaries was divided among insurers and other health care providers (e.g., doctors, hospitals). Nevertheless, the high correlation between pass-through and insurer market concentration is a powerful indication that insurers are likely capturing the lion's share of the portion of payments going to providers. Other research supports this interpretation. Duggan, Starc, and Vabson (2016) found that a large MA payment increase was followed by a sharp, substantial rise in returns on the stocks of large MA insurers. At the same time, the share price of the largest publicly traded hospital company was unchanged. This indicates that investors made their own judgments about where the subsidies were going.

### Can Policy Increase Pass-Through?

Medicare provides health care to tens of millions of Americans and there is a national interest in ensuring the program provides affordable, high-quality health care. Thus, when payments to private MA insurers are raised, one goal of policy may be to pass along to beneficiaries as much of these subsidy increases as possible in the form of lower premiums and improved benefits.

Our research points to the important role of market power in determining the extent of MA subsidy pass-through. Beneficiaries in more competitive markets benefit more from subsidy increases—and suffer more from subsidy cuts—than their counterparts in less competitive markets.

This suggests that steps to increase market competition are key to boosting pass-through. We didn't examine what kinds of government initiatives would make MA markets more competitive. Put plainly, we don't know what works. We need to understand better what policies are effective in promoting competition. Nevertheless, even though examining specific policy proposals is outside the scope of our analysis, there is some indication that the number of competitors is an important factor. Consequently, measures to encourage new entrants to the MA market may be worth exploring.

Our research is particularly relevant to one of the most contentious questions on the health policy agenda: what to do with the Affordable Care Act (ACA). As mentioned earlier in this policy brief, the ACA provided for \$156 billion in MA subsidy reductions. Our results indicate that these reductions have been borne only partially by Medicare beneficiaries, with a significant fraction of the cuts falling on insurers and other providers. If the ACA were repealed, higher payments to MA plans would be restored. Our results indicate market power would be a key factor determining how these gains would be apportioned.

Our study looked at the MA program in the early 2000s, but insurance markets are still dominated by a small number of insurers. In 2014, 88 percent of MA markets had a Herfindahl-Hirschman Index measure of insurance competition that met the regulatory definition of highly concentrated. In most parts of the United States, MA plan competition is in short supply—suggesting that limited pass-through of subsidies remains a pressing concern for seniors who depend on Medicare for health care coverage.

## References

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